

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

07288

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 27 days

Hospital, institution, or street address where death occurred:

Easton Memorial Hosp.

How long in hospital or institution? 27 days

3. (a) FULL NAME

Mrs. Lillian Arrington

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

7

W.

widowed

6. (b) Name of husband or wife

Walter Arrington

7. Birth date of deceased (mo., day, yr.)

8. (c) If alive, give age years

Nov. 14, 1889

8. AGE: Years

Months

Days

If less than one day

56

7

9

hrs.

min.

9. Birthplace

(Town, county, and state)

Balbot Co. Md.

10. Usual occupation

H.W.

11. Industry or business

MOTHER FATHER

12. Name John Marshall

13. Birthplace Md.

14. Maiden name Henrietta Ball

15. Birthplace Md.

16. Informant Mrs. Lillian Parrott

Address Oxford Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

7/27/46
(month) (day) (year)

Cemetery or crematory Spring Hill

Location

F. Ellis Clark Lums.

18. Funeral director

Address

19. Date rec'd by registrar

19

n.f. Nellius

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Talbot

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 23

19

46 at 5:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

6/27/46 1946 to 7/23 1946

and that I last saw her alive on 7/23/46 1946

Immediate cause of death

Hemorrhage, by. rt since

DURATION

3/3/46

Due to Diabetes mellitus

severe yes

Due to

Other conditions chronic myocarditis

6 months

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

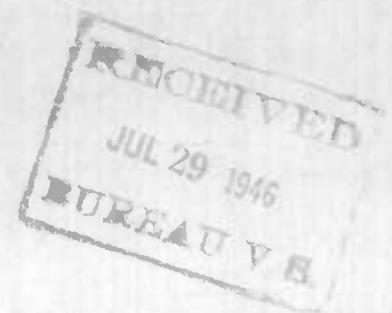
Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed 7/26/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 3rd

CERTIFICATE OF DEATH

Reg. Dist. No. 222

1. PLACE OF DEATH: Dalbot
 County: Oxford
 City or town: Oxford
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? _____
 Hospital, Institution, or street address where death occurred: _____
 How long in hospital or institution? _____

3. (a) FULL NAME

MINNIE DOBSON BARWICK

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced		
<u>Female</u>	<u>White</u>	<u>Married</u>		
6. (b) Name of husband or wife.		<u>Harry C Barwick</u>		
6. (c) If alive, give age <u>66</u> years				
7. Birth date of deceased (mo. day, yr.)	<u>Aug. 1, 1882</u>			
8. AGE:	Years <u>63</u>	Months <u>11</u>	Days <u>13</u>	If less than one day
				.hrs. min.

9. Birthplace: Oxford, Talbot, Md.
 (Town, county, and state)10. Usual occupation: Housewife11. Industry or business: At Home12. Name: Jane Dobson13. Birthplace: Md.14. Maiden name: Mary Dobson15. Birthplace: Delaware16. Informant: Mrs. Tom GermainAddress: Baltimore, Md.17. Burial: Oxford Cemetery
 Date thereof: July 17, 1946
 (Burial, cremation, or removal) (Which?)Cemetery or crematory: Oxford CemeteryLocation: Dalbot, Md. (rural)18. Funeral director: J. E. ClarkAddress: Easton, Md.19. Date rec'd by registrar: 7/15/46 19. Date signed: 7/16/46

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State: Maryland County: Talbot
 City or town: Oxford
 (If outside city or town limits, write RURAL and give nearest town)

Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war: _____

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 15 19. 46 at 6.55 A.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
7/18/46 to 7/15/46 19. 46
 and that I last saw her alive on 7/14/46 19. 46

Immediate cause of death: apoplexy DURATION: 3 days
 Due to: Hypertension year: 3 years

Due to: _____
 Other conditions: _____
 (Include pregnancy within 8 months of death)

Major findings of operations: _____ Date of op.: _____

Autopsy results: _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: _____ Date of: _____

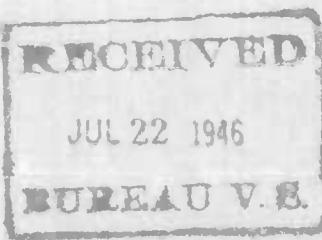
Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE: 13 M.D. or other: _____ Date signed: _____

Address: Easton Date signed: 7/16/46



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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 30

07290

CERTIFICATE OF DEATH

Reg. Diat. No. 891

1. PLACE OF DEATH:

County.....

City or town.....

Royal Oak

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....*all of life*

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

Murray Lloyd Brummel

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male Colored married

6. (b) Name of husband or wife.....

*Cora V. Beutley*6. (c) If alive, give age.....*49* years

7. Birth date of deceased (mo., day, yr.)

Jan 4-1896

8. AGE: Years

Months

Days

If less than one day

*50**6**10*

hrs.

min.

9. Birthplace.....

Royal Oak Md

(Town, county, and state)

10. Usual occupation.....

Farmer

11. Industry or business.....

Farm

MOTHER FATHER

12. Name.....

Lloyd Brummel

13. Birthplace.....

Royal Oak Md

14. Maiden name.....

Aurie Moore

15. Birthplace.....

Royal Oak Md

16. Informant.....

Cora V. Beutley

Address.....

Royal Oak, Md

17. Burial

Burial

(Burial, cremation, or removal, which?)

Date thereof.....*July 17-1946*
(month) (day) (year)

Cemetery or crematory.....

St Paul Catholic Cemetery

Location.....

Royal Oak, Md

18. Funeral director.....

Jerry G. Willard

Address.....

Castrol, Md.

19. Date rec'd by registrar.....

July 16 1946 John Beveridge

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

*July 14 1946*21. I CERTIFY that death occurred on the date above stated: that I attended deceased from
14 July 1946 to *14 July 1946*
and that I last saw him alive on *14 July 1946*

Immediate cause of death.....

Cardiac Failure

Due to.....

Heart Disease

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, tell in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

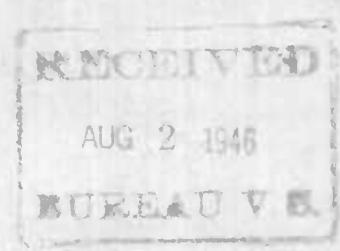
Injured at work?

23. SIGNATURE.....

W. Herbert Morrison

M. D. or other

Address.....*St. Michaels, Md.* Date signed *16 July 46*



VS A15
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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 232

07291

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

County

Elkton

City or town

Easton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Memorial Hospital, Easton

How long in hospital or institution?

15 hrs.

3. (a) FULL NAME

Mr. Ernest Levin

Carroll

4. Sex

5. Color or race

M.

W.

6.(a) Single, married, widowed, or divorced

married.

6.(b) Name of husband or wife

Mrs. Sallie Carroll

7. Birth date of deceased (mo., day, yr.)

April 8, 1882

6.(c) If alive, give age.....years

8. AGE:

Years

Months

Days

If less than one day

.....hrs.min.

9. Birthplace

Dorchester Co. Md.

(Town, county, and state)

10. Usual occupation

Merchant

11. Industry or business

FATHER

12. Name

Thomas Carroll

MOTHER

13. Birthplace

Md.

14. Maiden name

Annie Henry

15. Birthplace

Md. C

16. Informant

Mrs. Sallie J. Carroll

Address

Denton Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof July 11, 1946
(month) (day) (year)

Cemetery or crematory

Denton

Location

Denton, Maryland

18. Funeral director

Troy & Wood & Son

Address

Denton, Maryland

19. (Date rec'd by registrar)

19. 7/8/46

(Date rec'd by registrar)

19. 7/8/46

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Fells Point, Caroline

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 8

19. 46, 21, 235

21. I CERTIFY that death occurred on the date above stated; that attended deceased from

July 7

19. 46

to July 8, 1946

and that I last saw him alive on July 8, 1946

July 8, 1946

19. 46

Immediate cause of death

Cardiac failure

7 Lungs pulmonary edema,
Cerebral hemorrhage, accident

DURATION

Due to

Due to

Other conditions

Cholera

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Dr. John Harrison M.D.

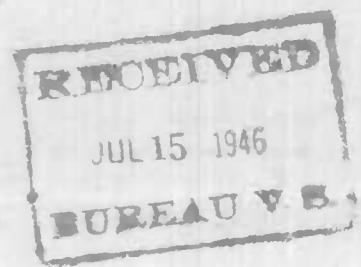
M. D. or other

Address

Fells Point, Md.

Date signed

7/8/46



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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 4A

07293

CERTIFICATE OF DEATH

Reg. Dist. No. 240

1. PLACE OF DEATH:

County

Baltimore

City or town

Queen Anne

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

25 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Minnie Cora Lee Clark

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

F.

W.

Unmarried

Harry Clark

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Oct. 18, 1870

6. (c) If alive, give age

years

8. AGE:

Years

75

Months

8

Days

19

If less than one day

hrs.

min.

9. Birthplace

Baltimore County

(Town, county, and state)

10. Usual occupation

Housekeeper

11. Industry or business

C.C. Cebula

FATHER

12. Name

C.C. Cebula

13. Birthplace

Md.

MOTHER

14. Maiden name

- Baile

15. Birthplace

-

16. Informant

Mrs. Mary Carlson

Address

Baltimore Md.

17. Cemetery or crematory

Burier

Date thereof

July 12, 1946

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Crematorium

Location

Bellevue Md.

Religious

Funeral director

R. E. Clark

Address

Baltimore Md.

18. Funeral director

R. E. Clark

Address

Baltimore Md.

19. Date rec'd by registrar

27/10/46

19. 46

N. H. Morris

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

Baltimore

City or town

Queen Anne

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 7, 1946, at 9:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 19, 1941, to July 7, 1946,

and that I last saw her alive on July 7, 1946.

Immediate cause of death

Coronary occlusion

Thrombosis

Due to

Antherosclerosis

Due to

Bronchopneumonia

2 days

Other conditions

Obstruction

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

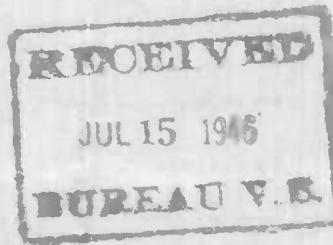
Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE: J. W. Lederer M.D.

M. D. or other

Address: Queen Anne Md. Date signed: 7/19/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83D

07292

CERTIFICATE OF DEATH

Reg. Dist. No. 297

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, Institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

Mary Eileen Cooney.

4. Sex

Female White virginal

5. Color or race

6.(a) Single, married, widowed, or divorced

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

Feb. 14, 1861

6.(c) If alive, give age.....

years

8. AGE:

Years 85 Months 4 Days 24 It less than one day hrs. min.

9. Birthplace.....

Doverchester Co., Md.

(Town, county, and state)

10. Usual occupation.....

Housewife -

11. Industry or business

Shakana

FATHER

12. Name.....

Shakana

13. Birthplace

Shakana

MOTHER

14. Maiden name.....

John Cantwelle

15. Birthplace

Shakana

16. Informant.....

John Cantwelle

Address.....

Grappe, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof.....

(month) (day) (year)

Cemetery or crematory.....

Old Cemetery

Location.....

Paulbridge, Md.

18. Funeral director.....

Maurice C. Peacock & Son

Address.....

Easton, Md.

19. Date rec'd by registrar.....

Jul 9- 1946

Date signed.....

Joseph B. Moore

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

None. -

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

July 8, 1946 at 6 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

December 1940 to July 1946

and that I last saw her alive on July 7th, 1946

Immediate cause of death.....

Hemiplegia

DURATION

4 days

Due to.....

Arteriosclerosis with Hypertension

10 yrs.

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

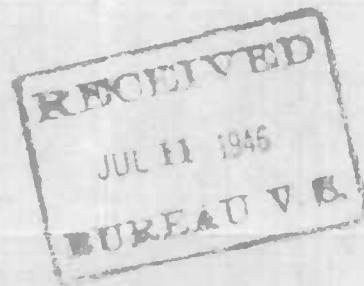
Means of injury..... Injured at work?

23. SIGNATURE.....

M. D. or other

Address..... Date signed.....

Grappe, Md. 7-9-46



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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07294

CERTIFICATE OF DEATH

Reg. Dist. No. 295

1. PLACE OF DEATH:

County TowsonCity or town Towson

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Dorothy Cecilia Davis

4. Sex

5. Color or race W. 6.(a) Single, married, widowed, or divorced Single.

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Sept. 1, 1911 6.(c) If alive, give age years

8. AGE:

Years 34 Months 10 Days 73 If less than one day hrs. min.

9. Birthplace

Towson, Maryland (Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Broadway, Towson

12. Name

Elizabeth M. Seay

13. Birthplace

Maryland

14. Maiden name

Elizabeth M. Seay

15. Birthplace

Maryland

16. Informant

Mr. Josephine M. Davis

Address

Towson, Md.

17. Burial

Burial Date thereof July 26, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Towson Cemetery

Location

Towson, Md.

18. Funeral director

J. G. Clark

Address

Towson, Md.

19. Date rec'd by registrar

July 21, 1946

Date signed

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County TowsonCity or town Towson (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 26, 1946 at 12:15 Mand that I last saw her alive on July 24, 1946 to 1946Immediate cause of death Cardiac decompensationDue to Chronic myocarditisDue to Chronic myocarditisOther conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op. Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of Where did injury occur? (City or town) (County) (State)Injured at home, farm, industry, public place (where?) Means of injury Injured at work?

23. SIGNATURE

Joseph L. Larson M. D. FatherAddress Towson, Md. Date signed July 25, 1946

RECEIVED

JUL 26 1946

BUREAU V B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 100

07295

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

County

Talbot

City or town

Easton Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 hours

Hospital, Institution, or street address where death occurred:

The Memorial Hospital

How long in hospital or institution?

7 hours

3. (a) FULL NAME

Clarence C. Dawson

4. Sex

M

5. Color or race

B

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Aug. 26 1926

6.(c) If alive, give age years

8. AGE: Years

19 yrs.

Months

11

Days

25

If less than one day

hrs.

min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

Farm work

11. Industry or business

Place of work - "The Plains"

MOTHER

FATHER

12. Name

William Carter

MOTHER

FATHER

13. Birthplace

Maryland

MOTHER

FATHER

14. Maiden name

Nancy Powell

MOTHER

FATHER

15. Birthplace

Maryland

MOTHER

FATHER

16. Informant

Mrs. Nancy Powell

MOTHER

FATHER

17. Address

Ridgeley Md.

MOTHER

FATHER

18. Cemetery or crematory

Burke Chapel

MOTHER

FATHER

19. Location

Near Cardova Md.

MOTHER

FATHER

20. Funeral director

P. B. Rawlings

MOTHER

FATHER

21. Address

Greensboro Md.

MOTHER

FATHER

22. Date rec'd by registrar

7/22 1946 M. H. Myers

MOTHER

FATHER

23. Registrar

M. D. or other

Address

Faylor, Maryland

Date signed

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn Infants give residence of mother)

State Md.

County Caroline

City or town Lidelity

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

7/21/46

19

at 4 P.M.

21. I CERTIFY that death occurred on the date above stated; that attended deceased from

July 21

1946, to

July 21 1946

and that I last saw him alive on July 21

Immediate cause of death Cardiac failure

& asphyxia

DURATION

Due to: Shot gun wound
penetrating of right chest

Due to:

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date

21 Jul 46

Where did injury occur

(City or town)

Ridgely, Caroline M.D.

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury Shot gun

Injured at work? No

23. SIGNATURE

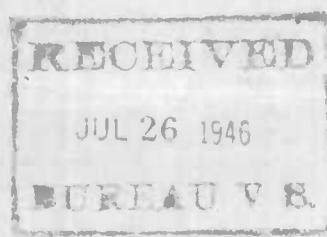
H. F. Klemm M.D.

M. D. or other

Address

Faylor, Maryland

Date signed 22 July 46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *Recd*

07296

CERTIFICATE OF DEATH

Reg. Dist. No. *281*

1. PLACE OF DEATH:

County *Talbot*City or town *St. Michaels*

(If outside city or town limits, write RURAL and give nearest town)

Life

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Home

How long in hospital or institution?

3. (a) FULL NAME

Susie Dennis

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

Colored

Widowed

8. (b) Name of husband or wife

Henry Dennis

7. Birth date of deceased (mo., day, yr.)

October 8, 1865

6. (c) If alive, give age

years

8. AGE:

Years
80Months
10Days
8

If less than one day

hrs.

min.

9. Birthplace

Talbot County

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Robert Miller

MOTHER FATHER

12. Name

Talbot County

13. Birthplace

Malinda Moore

14. Maiden name

Talbot County

15. Birthplace

Baltimore Dennis

16. Informant

St. Michaels

Address

17. Burial

Date thereof *July 18 1946*

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

St. Michaels

Location

18. Funeral director

J. Norman Marshall

Address

St. Michaels, Maryland.

19. Date rec'd by registrar

July 18 1946

(Date rec'd by registrar)

John G. Williams
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland* County *Talbot*City or town *St. Michaels*

(If outside city or town limits, write RURAL and give nearest town)

Street No. *Roll's Lane*

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH *July 15th* 1946 at *2 a.m.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 10th 1946 to *July 15* 1946and that I last saw him alive on *July 14th* 1946IMMEDIATE CAUSE OF DEATH *Valvular heart disease (mitral and aortic)*DURATION *do not know*DUE TO *do not know*

DUE TO

OTHER CONDITIONS

(Include pregnancy within 8 months of death)

MAJOR FINDINGS OF OPERATIONS

DATE OF OP.

AUTOPSY RESULTS

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

ACCIDENT, SUICIDE, OR HOMICIDE

DATE OF

WHERE DID INJURY OCCUR?

(CITY OR TOWN)

(COUNTY)

(STATE)

INJURED AT HOME, FARM, INDUSTRY, PUBLIC PLACE (WHERE?)

MEANS OF INJURY

INJURED AT WORK?

23. SIGNATURE *John G. Williams, M.D.* M. D. or otherADDRESS *St. Michaels, Maryland* DATE SIGNED *July 16, 1946*

RECEIVED

AUG 2 1946

BUREAU V E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *Md.*

07297

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

County *Talbot*City or town *Easton*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *three days*Hospital, institution, or street address where death occurred: *Easton Memorial Hosp.*How long in hospital or institution? *3 - three days*

3. (a) FULL NAME

Mr. James E. Duvall

4. Sex

5. Color of race

6. (a) Single, married, widowed, or divorced

*M. W.**M*

6. (b) Name of husband or wife

*Mr. James Duvall*6. (c) If alive, give age *50* years

7. Birth date of deceased (mo., day, yr.)

Feb. 3, 1895

8. AGE:

Years

Months

Days

If less than one day

*51.**5**3**#**hrs.**5**min.*

9. Birthplace

Talbot Co. Md.

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

Wm. J. Duvall

12. Name

Wm. J. Duvall

13. Birthplace

Talbot Co. Md.

14. Maiden name

Ella Collins

15. Birthplace

Talbot Co. Md.

16. Informant

Wm. J. E. Duvall

Address

Easton Md.

17. Burial

Burial

Date thereof

7/9/46

(Burial, cremation, or removal, which?)

(month) (day) (year)

Cemetery or crematory

Spruce Hill

Location

Easton Md.

18. Funeral director

Wm. E. Yerkes & Son

Address

*Easton Md.*19. *7/2**19. 46*

Date rec'd by registrar

Dr. H. Nease

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland* County *Talbot*City or town *Easton*

(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 6 1946 at 7:05 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*July 3 1946 to July 6 1946*and that I last saw him alive on *July 6 1946*

Immediate cause of death

Trauma to right chest.

Due to

Accident

Due to

Acute Glaucoma

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

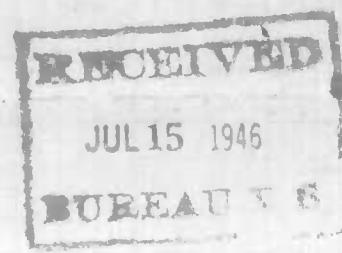
Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide *Accident* Date of *July 6 1946*Where did injury occur? *Easton Talbot Md.* (City or town) (County) (State)Injured at home, farm, industry, public place (where?) *public place*Means of injury *falling fence*. Injured at work? *No*23. SIGNATURE *Wm. J. Baetz M.D.* M. D. or otherAddress *7 Gold St. Easton* Date signed *7-7-46*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *92-B*

CERTIFICATE OF DEATH

07298

Reg. Dist. No. 290

1. PLACE OF DEATH

County

City or town

*Gulbot**Baltimore*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred

18 South St.

How long in hospital or institution?

3. (a) FULL NAME

DONALD EDWARD ERSKINE

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

8

Months

8

Days

13

6. (c) If alive, give age years

If less than one day

hrs.

min.

9. Birthplace

(Town, county, and state)

Easton, Md.

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

Cemetery or crematory

Location

18. Funeral director

Address

19. Date rec'd by registrar

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

City or town

*Easton**Md.*

Street No.

*118**South St.**South**St.*

(If rural, give LOCATION)

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 18 1946 at 9:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*June 22 1946 to July 18 1946*and that I last saw him alive on *July 18 1946*

Immediate cause of death

Acute Nephritis

DURATION

3 Mths.

Due to

Due to

Other conditions

*Mitral Insufficiency**second year.*

(Include pregnancy within 8 months of death)

Major findings or operations

no

Date of op.

Autopsy results

no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

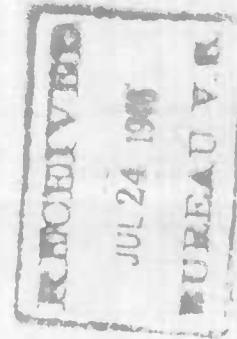
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

R. H. C. Stevens M. D. or otherAddress *Easton Md* Date signed *7-19-46*



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 23-2

CERTIFICATE OF DEATH

Dr. Welch
07299

Reg. Dist. No. 290

1. PLACE OF DEATH:

County.....*Talbot*City or town.....*Easton*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....*all of life*

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

Mary Magdalene Henry

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female Colored Widow

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.).....*June 19-1879-*

6. (c) If alive, give age..... years

8. AGE: Years.....*67* Months.....*1* Days.....*9* If less than one day

hrs..... min.....

9. Birthplace.....*Talbot Co., Md.*

(Town, county, and state)

10. Usual occupation.....*Housework*11. Industry or business.....*George W. Johnson*12. Name.....*George W. Johnson*13. Birthplace.....*Richmond, Va.*14. Maiden name.....*Mary E. Woolley*15. Birthplace.....*Frederickville, Md.*16. Informant.....*Nathaniel Johnson*Address.....*Easton, Md.*17. Burial.....*Burial*Date thereof.....*Aug. 24-46*

(Burial, cremation, or removal, which?)

(day) (year)

Cemetery or crematory.....*Oglebacks Cemetery*Location.....*Easton, Md.*18. Funeral director.....*John D. Kelley*Address.....*Easton, Md.*19. Date record by registrar.....*7/30*19. Date record by registrar.....*1946*19. Date record by registrar.....*M.A. Morris*Registrar.....*John D. Kelley*

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....*Md.*County.....*Talbot*City or town.....*Easton*

(If outside city or town limits, write RURAL and give nearest town)

Street No.....*E - South St*

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH:

July 28th 1946

I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 28 1946 to *July 28* 1946and that I last saw him alive on *July 28* 1946

Immediate cause of death:

Cerebral Hemorrhage

DURATION

Due to.....*Hypertension*

1-2 years

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

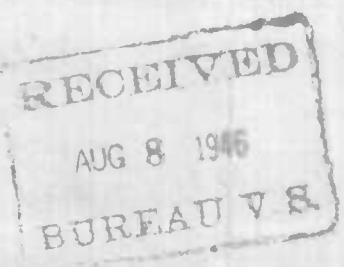
Means of injury..... Injured at work?

23. SIGNATURE

Haymed J. Deft, M.D.

M. D. or other

Address.....*Easton, Md.*Date signed *7/30/46*



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 740

07300

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

William James Hopkins

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male

white

married

6. (b) Name of husband or wife

Hopkins

Sally H. Bradford

78

7. Birth date of

deceased (mo., day, yr.)

October 23, 1862

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

83

8

9

hrs.

min.

9. Birthplace

(Town, County, and state)

Kent Island, Md.

10. Usual occupation

retired gardener

11. Industry or business

FATHER

William J. Hopkins

MOTHER

Mary Ann J.

13. Birthplace

Rebecca Cooper

15. Birthplace

Maryland

16. Informant

Mrs. Sally H. Hopkins

Address

Cordova

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof July 31 1946

(month) (day) (year)

Cemetery or crematory

Spring Hill Cemetery

Location

Easter Blvd

18. Funeral director

John D. Williams

Address

Easter Blvd

19. Date rec'd by registrar

1946

D. H. Nease

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Talbot

City or town..... Cordova

(If outside city or town limits, write RURAL and give nearest town)

Street No..... Main St

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 1 1946 at 2 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

October 1945 to May 1 1946

and that I last saw him alive on May 1 1946

Immediate cause of death

Coronary occlusion

DURATION

Due to Generalized arterio-sclerotic

7 years

Sclerotic

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

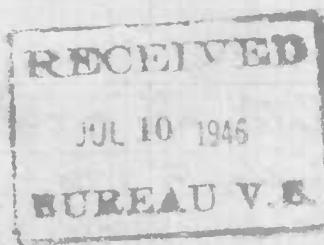
Injured at work?

23. SIGNATURE

M. D. or other

Address..... Green Anne's Md 7/1/46

Date signed



PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 07301 290

1. PLACE OF DEATH:

County CarolineCity or town Easton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? six days

Hospital, institution, or street address where death occurred:

Sixty Four Maryland HwyHow long in hospital or institution? six days

3. (a) FULL NAME

Charles J. Johnson

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M. B. single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Sept. 4, 1876 72 yrs old8. AGE: 69 Years Months 10 Days 15 If less than one day 8 hrs. 45 PM9. Birthplace Grasonville, Md.
(Town, county, and state)10. Usual occupation Farmer

11. Industry or business

12. Name Nathan Henry Johnson13. Birthplace Grasonville, Md14. Maiden name Rebecca Steward15. Birthplace Carnegie, Md16. Informant Nathan JohnsonAddress Grasonville, Md17. Burial Date thereof 7/23/46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Ridgeway AM CemeteryLocation Grasonville, Md.18. Funeral director John WallaceAddress Easton, Md.19. Date rec'd by registrar 7/23/46 N. F. Nease
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty TalbotCity or town Grasonville, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20 1946 19 46 at 11:45 AM

21. CERTIFY that death occurred on the date above stated; that I attended deceased from

July 14 1946 to July 20 1946and that I last saw him alive on July 20 1946Immediate cause of death Angina Pectoris

DURATION

2 weeks

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

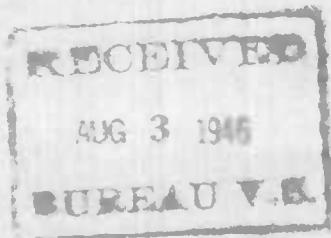
Means of injury

Injured at work?

23. SIGNATURE M. V. Palmer M.D.

M. D. or other

Address Easton, Md.Date signed 2/12/46



I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 28

07302

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 hrs. 40 min.

Hospital, Institution or street address where death occurred:

Memorial Hospital
3 hrs. 40 min.

How long in hospital or institution?

3. (a) FULL NAME

Mrs. Blanche Jones

4. Sex

f.

5. Color or race

w

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Aug. 22 - 1909

8. (c) If alive, give age

years

8. AGE: Years

Months

Days

If less than one day

38

10

26

hrs.

min.

9. Birthplace

Rising Sun, Cecil Co. Md.

(Town, county, and state)

10. Usual occupation

phone

11. Industry or business

FATHER

12. Name

Mr. Andrew Jones

Cecil Co. Md

13. Birthplace

14. Maiden name

Mrs. Myrtle Subert

Cecil Co. Md

15. Birthplace

16. Informant

Andrew J. Jones

Address

Centerville, Md.

17. Burial

(Burial, cremation, or removal which)

Date thereof July 21-46

(month) (day) (year)

Cemetery or crematory

Chesterfield

Location

Centreville, Maryland

18. Funeral director

Doctor T. D. Davis

Address

Centreville, Maryland

19. Date rec'd by registrar

7/20

19.

46

N. S. Davis

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md.

County.....

Wicomico

City or town.....

Salisbury, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

7/18/46

19.

at 10:46 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

7/18/46 19. to. 7/18 19. at 10:46 P.M.

and that I last saw h. m. alive on 7/18/46 19.

Immediate cause of death

Acute Hepatitis

DURATION

Due to

Hepatitis

Due to

Other conditions

Acute Pancreatitis

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

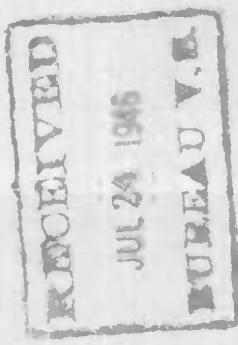
M. V. Palmer

M. D. or other

Address

Easton, Md.

Date signed 7/20/46



PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B)

07303

CERTIFICATE OF DEATH

Reg. Dist. No. 294

1. PLACE OF DEATH:

County..... Talbot
City or town..... Sherwood

(If outside city or town limits, write RURAL and give nearest town)

Nine years

How long in above place of death?.....
Hospital, Institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

Lola Lula Savage Jordan

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female Colored Married

6. (b) Name of husband or wife..... Lawrence Jordan

49

6. (c) If alive, give age years

7. Birth date of deceased (mo. day, yr.)..... April 24 1891

8. AGE: Years Months Days If less than one day
55 3 3 hrs. min.

9. Birthplace..... Accomac Co. Virginia

(Town, county, and state)

10. Usual occupation..... Housewife

11. Industry or business..... Own home

12. Name..... George Savage

13. Birthplace..... Accomac Co. Virginia

14. Maiden name..... Mary Pitts

15. Birthplace..... Accomac Co. Virginia

16. Informant..... Daisy Johnson

Address..... Sherwood Maryland

17. Burial

(Burial, cremation, or removal. Which?)..... Date thereof..... 7-29-46

Cemetery or crematory..... Sherwood Colored

Location..... Sherwood Maryland

18. Funeral director..... J. Norman Marshall

Address..... St. Michaels

19. Date recd by registrar..... July 30th 1946Anna C. Thomas
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State..... Maryland County..... Talbot

City or town..... Sherwood

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

212-18-6959

MEDICAL CERTIFICATION

20. DATE OF DEATH..... July 25 1946, et 10:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 25 1946, to July 25 1946

and that I last saw her alive on July 24 1946

Immediate cause of death.....

Cerebral Hemorrhage

Due to..... Neglectous

Due to..... arteriosclerosis

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

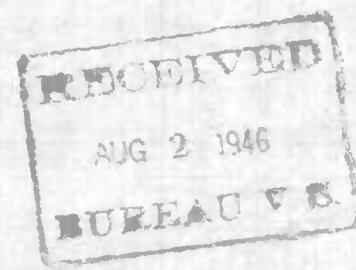
Means of injury.....

Injured at work?

23. SIGNATURE

George A. Lee, M.D. or other

Address..... W. Johnson, Jr. Date signed..... July 30, 1946



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age
is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of birth date of deceased is shown on MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore 510
FILM No. I 06 JUL 31 1946

07304

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

County.....

Talbot

City or town.....

Easton Md

(If outside city or town limits, write RURAL and give nearest town)

19 das.

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Memorial Hospital, Easton Md

How long in hospital or institution?

3. (a) FULL NAME

Mr. Fred Kinsley

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

m w Widowed

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

6.(c) If alive, give age..... years

May 2 - 1875 1876

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace.....

(Town, county, and state)

Pa.

10. Usual occupation.....

Machineist

11. Industry or business

12. Name.....

John M. Kinsley

13. Birthplace.....

Pa.

14. Maiden name.....

Sarah Reynolds

15. Birthplace.....

Pa.

16. Informant.....

Wellard Kinsley

Address

Chesterstown Md

17. Burial.....

Date thereof..... July 31 1946

(Burial, cremation, or removal, month)

(month) (day) (year)

Cemetery or crematory.....

Chester

Location.....

Chester County Md

18. Funeral director.....

Edward Eller

Address

Millington Md.

19. Date rec'd by registrar

19 46

D.S. Neerey

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Kent

City or town..... Chester Town

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

218-03-9232

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 1 19 46 at 6⁰⁵ A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 12 19 46 to July 1 19 46 and that I last saw him alive on July 1 19 46

Immediate cause of death.....

Coronary Disease

Due to..... Cardiac Arrest

Due to.....

Other conditions Coronary Prostate

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE

M. D. or other

Address..... Euston Md Date signed..... 7/1/46

RECEIVED

JUL 10 1946

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 970

07305

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

County Talbot
City or town Eaton Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 minutes

Hospital, Institution, or street address where death occurred:

Memorial Hospital, Eaton, Md.How long in hospital or institution? 20 minutes

3. (a) FULL NAME

Ferdinand Kruger

3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Clara Kruger7. Birth date of deceased (mo. day, yr.) Sept 4, 1877 6. (c) If alive, give age years8. AGE: Years 68 Months 10 Days 11 It less than one day hrs. min.9. Birthplace Germany (Town, county, and state)10. Usual occupation farmer

11. Industry or business

12. Name Julius Kruger13. Birthplace Germany14. Maiden name Augusta Hoback15. Birthplace Germany16. Informant Mr. & Mrs. Kruger wifeAddress Preston, Md.17. Burial Date thereof 7/18/46 (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory U. S. A. M.Location Preston Md.18. Funeral director Harry GreenAddress Preston, Md.19. Date record by registrar 7/17/46 7/18/46 Howard L. Kerman

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CarolineCity or town Preston (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15 t9 46 at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 15 1946, to July 15 1946, and that I last saw him alive on July 15 1946.

Immediate cause of death

Coronary Thrombosis DURATION 2 hrs

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations No one

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

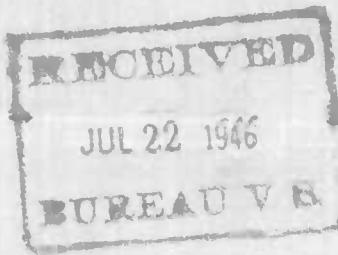
Means of injury

Injured at work?

23. SIGNATURE Howard L. Kerman

M. D. or other

Address Baltimore Maryland Date signed July 16 1946



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 170-2

07306

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:
County *Talbot*

City or town *Baltimore*
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *2 Days*

Hospital, institution, or street address where death occurred:
Baltimore Memorial Hospital

How long in hospital or institution? *2 Days*

3. (a) FULL NAME

*DAVID FLANNIGAN Mc CALLISTER JR.*4. Sex *Male* 5. Color or race *White* 6. (a) Single, married, widowed, or divorced *Married*6. (b) Name of husband or wife *Cillian Mc Callister*7. Birth date of deceased (mo., day, yr.) *November 3, 1896*8. AGE: Years *49* Months *8* Days *18* If less than one day
hrs. min. 9. Birthplace *Pennsylvania*
(Town, county, and state)10. Usual occupation *Baker*11. Industry or business *Catering*12. Name *David Flannigan Mc Callister*13. Birthplace *Phila. Pa.*14. Maiden name *Fannie P. Grant*15. Birthplace *Maine*16. Informant *Baltimore Memorial Hospital Records*Address *Baltimore, Md.*17. Burial Date thereof *July 24, 1946*
(Burial, cremation, or removal, which?) Date (month) (day) (year)Cemetery or crematory *Clothington*Location *High & Hill Pa.*18. Funeral director *David Brown & Son*Address *4951 Catherine St. - Phila. Pa.*19. *7/22 1946* N. H. Morris

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)State *Pennsylvania* County *Philadelphia*City or town *Philadelphia*
(If outside city or town limits, write RURAL and give nearest town)Street No. *7105 Clayne Ave* (If rural, give LOCATION) *Lywood*

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH *July 21st* 1946 at 6:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw h. alive on 19.

Immediate cause of death.....

Due to *Crushing injury to chest* DURATION *40 hrs*Due to *Auto accident*

Due to

Other conditions

(Include pregnancy within 3 months of death)

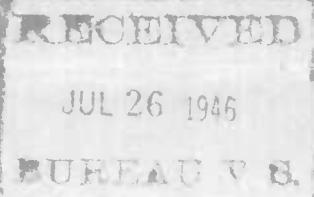
Major findings of operations..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide *accident* Date of *7-19-46*Where did injury occur? *in Eastern Talbot Md* (City or town) (County) (State)Injured at home, farm, industry, public place (where?) *public places*Means of injury *car face* Injured at work? *No*23. SIGNATURE *Louis S. Herby M.D. D.P.M. D.A.B.O.G.* M.D. or otherAddress *Baltimore Md* Date signed *7-22-46*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 183

07307

CERTIFICATE OF DEATH

Reg. Dist. No. 291

1. PLACE OF DEATH: T
County Chesapeake Bay

City or town.....
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Donald Ralph Miller

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) 3 - 6 - 1919 6. (c) If alive, give age..... years

8. AGE: Years 27 Months 4 Days 19 If less than one day hrs. min.

9. Birthplace Norristown, Pa.
(Town, county, and state)

10. Usual occupation Bricklayer

11. Industry or business Geo. Bauckman

FATHER 12. Name Allan J. Miller

MOTHER 13. Birthplace Philadelphia, Pa.

14. Maiden name Rachel J. Smythe

15. Birthplace Norristown, Pa.

16. Informant Allan J. Miller

Address 3621 First Rd. South

17. Burial Arlington, Va. Date thereof 8/6/46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Arlington National Cemetery

Location Arlington, Va.

18. Funeral director J. Norman Marshall

Address St. Michaels, Md.

19. 8-3- Date rec'd by registrar 19 John G. Hawley Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Virginia County ArlingtonCity or town Arlington (If outside city or town limits, write RURAL and give nearest town)Street No. 3621 First Road (If rural, give LOCATION)2.(a) If veteran, name war World War #23. (b) Social Security Number 161-14-3561

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25th 1946 GP M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19..... to 19.....

and that I last saw him alive on 19.....

Immediate cause of death.....

Accidental drowning

Due to.....

Doctor Body recovered 8-3-46
C.S.P.M. off. Sharps Island

Other conditions Light-fishing out of
Chesapeake Beach Ind. (Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide. Accident Date of 7-25-46Where did injury occur? Chesapeake Bay "Groves" (City or town) (County) (State)Injured at home, farm, industry, public place (where?) BayMeans of injury drown Injured at work? No23. SIGNATURE Louis D. Hart MD M. D. or other Orthopaedic Date signed 8-3-46Address Easton Md.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 920

CERTIFICATE OF DEATH

07308

Reg. Dist. No. 290

1. PLACE OF DEATH:
County Talbot

City or town Sisson, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, Institution, or street address where death occurred:
Memorial Hospital

How long in hospital or institution? 1 day

3. (a) FULL NAME

James Edmund Neal

4. Sex

5. Color or race White
Male Married

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

Grace W. Neal

7. Birth date of deceased (mo., day, yr.)

Sept. 11, 1891

6. (c) If alive, give age years

8. AGE:

Years	Months	Days	It less than one day
54	10	12	

hrs. min.

9. Birthplace

Denton, Md.
(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

J. Dallas Neal

12. Name

MOTHER FATHER

13. Birthplace

Mary R. Green

14. Maiden name

J. md.

15. Birthplace

Grace W. Neal

16. Informant

Address

Burial

(Burlap, cremation, removal, etc.)

Date thereof

(month) (day) (year)

Cemetery or crematory

East New Market

Location

East New Market

Md.

18. Funeral director

S. Harvey Williamson

Address

Federal'sburg, Md.

19. Date reg'd by registrar

7/23/46

1946

n. H. Chevius

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Caroline!

City or town Federalsburg (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

No

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-23-46 at 1 P.M. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 22, 1946, to July 23, 1946, and that I last saw him alive on July 23, 1946.

Immediate cause of death

mitral insufficiency decompenating

Due to

Due to

Other conditions accites, - obesity

enlargement of liver
(Include pregnancy within months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

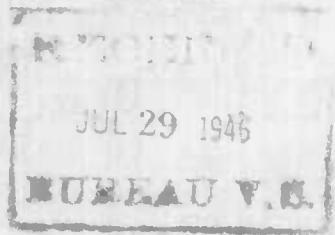
Injured at work?

23. SIGNATURE

P. Cox M.D.

M. D. or other

Address Eason, Md. Date signed 7/24/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 930

CERTIFICATE OF DEATH

Reg. Dist. No. 297

D. Harrison
07309

1. PLACE OF DEATH:

County BaltimoreCity or town Oxford

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Muriel Alberta Parrott4. Sex F 5. Color or race W. 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Clarence Herbert Bennett7. Birth date of deceased (mo., day, yr.) February 17, 1890 6. (c) If alive, give age 70 years8. AGE: Years 76 Months 4 Days 24 If less than one day hrs. min.9. Birthplace Baltimore County, Maryland

(Town, county, and state)

10. Usual occupation Housewife11. Industry or business Edward Lawers.12. Name Edward Lawers.13. Birthplace Md.14. Maiden name Nicola15. Birthplace Md.16. Informant Mr. Harry DeaconAddress Oxford, Md.17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof July 12, 1946

(month) (day) (year)

Cemetery or crematory Spring HillLocation Oxford, Md.18. Funeral director Bobbi BlackAddress Oxford, Md.19. July 12, 1946 Date rec'd by registrar

(Date received by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty OxfordCity or town Oxford

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 11 1946 at 11:50 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

24 June 1946 to 7 July 1946and that I last saw her alive on 7 July 1946 1946

Immediate cause of death

Cardiac failure

DURATION

(?)

Due to arterial hypertension 2wkDue to cardiac arteriosclerosis ?Other conditions Hypertension and muscular disease

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

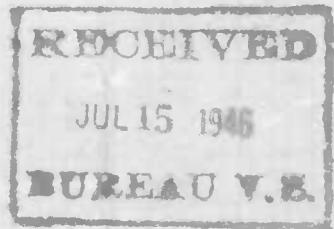
Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Cards being sent Date signed 12 July 46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 6

CERTIFICATE OF DEATH

07319
Reg. Dist. No. 290

1. PLACE OF DEATH:

County TalbotCity or town Easton Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, Institution, or street address where death occurred:

Memorial HospitalHow long in hospital or institution? 3 days

3. (a) FULL NAME

Mrs. Emma K. Phillips4. Sex F5. Color or race W6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Mr. Wm T. Phillips7. Birth date of deceased (mo., day, yr.) Aug. 5, 18816. (c) If alive, give age years8. AGE: Years 64Months 11Days 1

If less than one day

hrs. min. 9. Birthplace Delaware

(Town, county, and state)

10. Usual occupation Housewife11. Industry or business Own Home

MOTHER FATHER

12. Name Theodore Barlow13. Birthplace Delaware14. Maiden name Amanda15. Birthplace Delaware16. Informant William E. PhillipsAddress Easton, Md.17. Burial Buried

(Burial, cremation, or removal) Which?

Date thereof 7/9/46

(month) (day) (year)

Cemetery or crematory Spring HillLocation Satellite Md.18. Funeral director Black JackAddress Easton, Maryland19. 7/7

19.

46

Dr. H. Nease

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty TalbotCity or town Easton

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH July 6

1946, a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 3 1946, to July 6 1946,and that I last saw her alive on July 6 1946.Immediate cause of death Intracranial HemorrhageDURATION 3 daysDue to HypertensionDURATION 5 yearsDue to Other conditions Debilities, malnutrition - unable

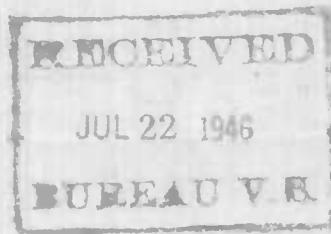
(Include pregnancy within 8 months of death)

Major findings of operations Date of op. Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of Where did injury occur? (City or town) (County) (State) Injured at home, farm, industry, public place (where?) Means of injury Injured at work? 23. SIGNATURE M. V. Palmer M.D.M.D. or other Address Easton, MarylandDate signed 7/9/46



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (6)

Dr. Webb

CERTIFICATE OF DEATH

Reg. Dist. No. 107311290

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... all of life -

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

Mary Gail Slaughter

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Female Colored married

6.(b) Name of husband or wife

John Slaughter

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

October 3-1884

8. AGE:

Years

Months

Days

If less than one day

62

9

1

hrs. min.

9. Birthplace.....

Copperville, Eastern Rural

(Town, county, and state)

10. Usual occupation.....

11. Industry or business

Other Thomas

12. Name.....

Copperville Md

13. Birthplace.....

Unknown

14. Maiden name.....

Mildred Parker

15. Birthplace.....

Easton Md

16. Informant.....

Burial

(Burial, cremation, or removal, which)

Date thereof (month) (day) (year)

Richard Cemetery

Cemetery or crematory.....

Easton Md.

Location.....

John D. Williams

18. Funeral director.....

Easton Md.

Address.....

Hayward T. Webb, M.D.

19. (Date rec'd by registrar)

7/6

9.46

N.H. Neerius

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md.

County.....

Talbot

City or town.....

Frost

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

S. Hanson - st

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

July 4th

1946, at 12: noon

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 3

1946, to July 4

1946

and that I last saw her alive on July 4

1946

Immediate cause of death.....

Acute Endocarditis

DURATION

6 mos

Doe fo.....

Due fo.....

Other conditions.....

Diabetes Mellitus

2-3 yrs

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE.....

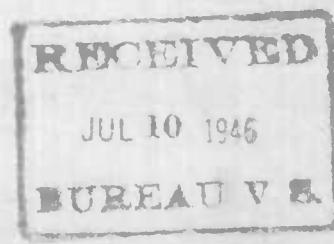
M. D. or other

Address.....

Frost, Md

Date signed

7/3/46



~~✓~~ PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore ⁽⁵⁰⁾

CERTIFICATE OF DEATH

07312
Dr. M. V. Palmer, M.D.
Reg. Dist. No. 290

1. PLACE OF DEATH:

County BaltimoreCity or town Baltimore (If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 yearHospital, Institution, or street address where death occurred: Longfield Apartments - S. Washington St.

How long in hospital or institution?

3. (a) FULL NAME

Edie Dale Smith4. Sex F5. Color or race W.6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Dec. 25, 18966.(c) If alive, give age years

8. AGE:

Years 49Months 6Days 15

If less than one day

hrs.

min.

9. Birthplace Columbia, Va.

(Town, County, and state)

10. Usual occupation H.W.11. Industry or business Wallace M. Smith

MOTHER FATHER

12. Name Wallace M. Smith13. Birthplace Virginia14. Maiden name Dale Harris15. Birthplace Virginia16. Informant J. H. Harris SmithAddress Baltimore, Md.17. Cremation Cremation(Burial, cremation, or removal. Which?) Date thereof July 15, 1946 (month) (day) (year)Cemetery or crematory Hanover ParkLocation Baltimore, Md.18. Funeral director Reed ClarkAddress Baltimore, Md.19. 7/1219. 46

(Date rec'd by registrar)

Registrar M. H. Morris

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.County BaltimoreCity or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. Longfield Apartments - S. Washington St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10

1946 at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 20 1946, to July 10 1946,and that I last saw her alive on July 10 1946.

Immediate cause of death

Generalized Convulsions

DURATION

Due to Carcinoma of Breast

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?)

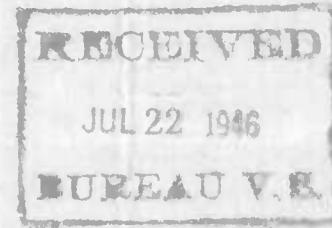
Means of injury

Injured at work?

23. SIGNATURE M. V. Palmer, M.D.

M. D. or other

Address Baltimore, MarylandDate signed 7/14/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1210

07315

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

County GallatinCity or town Evanston

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 23

Hospital, institution, or street address where death occurred:

Eastern Memorial Hosp.How long in hospital or institution? 23

3. (a) FULL NAME

Mrs. Bella Remona Thieroff

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

W. (m)

6. (b) Name of husband or wife

Mrs. Edwin Thieroff

7. Birth date of deceased (mo., day, yr.)

Aug. 31, 18848. (c) If alive, give age 61 years

8. AGE:

Years 61 Months 10 Days 24 If less than one day

hrs. min.

9. Birthplace

Auburn, Indiana

(Town, county, and state)

H.W.

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name J. B. Cox13. Birthplace Auburn, Indiana14. Maiden name Marie Prosser15. Birthplace Auburn, Indiana

16. Informant

E.H.E. Thieroff

Address

Preston Md.Date thereof July 26, 1946

(Burial, cremation, or removal. Which?)

Cemetery or crematory J. O. U. A. M.Location Preston Md.

18. Funeral director

O. H. J. HollisAddress Preston Md.19. 7/24 1946

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty BaltimoreCity or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

7/24/46 1946 at 4:30 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 24, 1946, to July 24, 1946 and that I last saw her alive on July 24, 1946.

Immediate cause of death

Cardiac arrestis of brain DURATION 6 months?Due to Congestive Heart Failure1946Due to Adenomatous Adrenocortical Disease

age

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

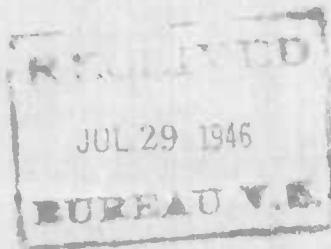
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Mrs. Palmer M.D. or otherAddress Eastern Md. Date signed 7/27/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

CERTIFICATE OF DEATH

07314

290

Reg. Dist. No.

1. PLACE OF DEATH:

County *Carroll*City or town *Carlton*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *5 yrs.*

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

C. Wilson Trice

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

*M.**w.**Maurice*

6.(b) Name of husband or wife

*Bailey M. Trice*B.(c) If alive, give age *38* years

7. Birth date of deceased (mo., day, yr.)

Feb. 10, 1899

8. AGE:

Years
*47*Months
*5*Days
*7*If less than one day
hrs.
min.

9. Birthplace

Carroll, Delaware

(Town, county, and state)

10. Usual occupation

Miner

11. Industry or business

MOTHER FATHER

12. Name *Howard L. Trice*13. Birthplace *Delaware*14. Maiden name *Gandy*15. Birthplace *New Jersey*16. Informant *Mrs. C. Wilson Trice*Address *Carlton, Md.*

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof *July 19, 1946*
(month) (day) (year)Cemetery or crematory *Spring Hill*Location *Carlton, Md.*18. Funeral director *John Keay*Address *Carlton, Md.*

19. Date rec'd by registrar

7/22 1946

(Date rec'd by registrar)

M. H. Morris

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Md.*County *Carroll*City or town *Carlton*

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

717-03-9221

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 17

19

46

at

235A

M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Polkker 1945, to *July 16* 1946and that I last saw him alive on *July 16* 1946

Immediate cause of death

*Pulmonary tuberculosis**Mostly spread*

DURATION

4 years

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

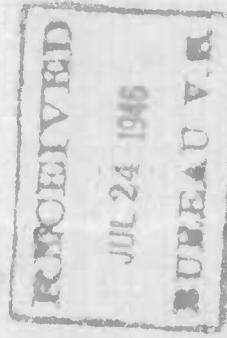
23. SIGNATURE

M. H. Morris 7/22

M. D. or other

Address

*Carlton, Md.*Date signed *7/22/46*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-2

CERTIFICATE OF DEATH

17315

Reg. Diat. No. 290

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

5 months

Hospital, Institution, or street address where death occurred:

Lester & DeKoven Ave

How long in hospital or institution?

3. (a) FULL NAME

Mrs. Ella Jasper

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Female white widow

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Sept. 11, 1860

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md. County Talbot

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 10, 1946, at

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19...

19...

and that I last saw h alive on

Immediate cause of death

Pneumonia, cardiac failure, anæmia.

DURATION

Due to arterio-sclerosis, general & cerebral

Due to arterio-venous sclerosis

Other conditions

Osteo-arthrosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

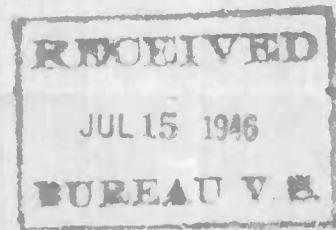
Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of place
of death is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 16

07316

Reg. Dist. No. 290

FILM No. 106 AUG 23 1946

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County

Easton

City or town

Rural County Road

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Memorial Hospital 3 days

How long in hospital or institution?

3. (a) FULL NAME

Eugenia Ward

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

X

B

6. (b) Name of husband or wife

Wm. Ward

7. Birth date of deceased (mo., day, yr.)

May 26, 1913

6. (c) If alive, give age

28

years

8. AGE:

Years

Months

Days

If less than one day

33

2

25

hrs.

min.

9. Birthplace

Savannah, Georgia

(Town, county, and state)

10. Usual occupation

H.W.

11. Industry or business

Field working summer

FATHER

12. Name

John Blackman

MOTHER

13. Name

John Blackman

14. Birthplace

Elmwood, Alabama

15. Maiden name

Ella Williams

16. Birthplace

Troy, Alabama

17. Informant

Zippie Williams

Address

Poynapple, Fla.

18. Burial, cremation, or removal

Burial

Date thereof

(month) (day) (year)

7/29/46

Cemetery or crematory

Richards

Location

Easton, Md.

19. Funeral director

John D. Williams,

Address

Easton, Md.

20. Date of death

July 21, 1946

21. CERTIFY that death occurred on the date above stated; that I attended deceased from

July 19, 1946, to July 21, 1946

and that I last saw him alive on July 21, 1946.

Immediate cause of death

Cardiac Failure

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Georgia

County

Savannah

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 21, 1946, at 8 A.M.

21. CERTIFY that death occurred on the date above stated; that I attended deceased from

July 19, 1946, to July 21, 1946

and that I last saw him alive on July 21, 1946.

Immediate cause of death

Cardiac Failure

DURATION

Due to

Toxemia & S. S. C.

Due to

Gun shot wound of

abdomen. Shot gun

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Pedobacter abd. wall

Pedobacter abd. walls large lower

Date of op. 19. July 46

Autopsy results

Same.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Homicide

Date of

19. July 46

Where did injury occur

Easton

(City or town)

(County)

(State)

public place

Injured at home, farm, industry, public place (where?)

Means of injury

Shot gun

Injured at work?

No

23. SIGNATURE

H. F. Kennedy, M.D.

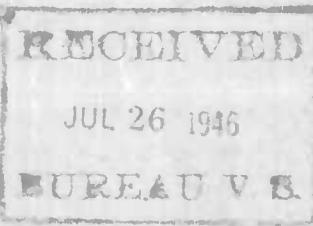
M. D. or other

Address

Easton, Maryland

Date signed

21 July



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Dr. Kelly
11/16/46

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

County Talbot

City or town Easton (Rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Dorothy Marie Young.

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female Colored

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age years

May 5-1946

8. AGE:

Years

Months

Days

If less than one day

1 29

hrs.

min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. Date rec'd by registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md

County Talbot

City or town Trappe Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 4th 1946 at 4 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19.

to

19.

and that I last saw him alive on

Immediate cause of death

Fractured skull

Auto accident

DURATION

Injured

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

accident

Date of

7-4-46

Where did injury occur?

in Easton Talbot MD

(City or town)

(State)

Injured at home, farm, industry, public place (where?)

public highway

(State)

Means of Injury

auto accident

(State)

Injured at work?

no

(State)

23. SIGNATURE

Loris J. Kelly MD Dep. Mortar

M. D. or other

Address

Date signed

RECEIVED

JUL 10 1946

REAU V.E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 4

CERTIFICATE OF DEATH

07318

Reg. Dist. No.

290

1. PLACE OF DEATH:

County

Salisbury
Trappe Rural Md

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

all of life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Lillian Hestelle Young

4. Sex

5. Color or race

6. (d) Single, married, widowed, or divorced

Female Colored

Widow

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

June 16-1899

8. AGE:

Years

Months

Days

If less than one day

47

20

hrs.

min.

9. Birthplace

(Town, County, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal, which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. Date rec'd by registrar

7/8

19. 46

N.B. Please

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md. County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

220-12-0080

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 6th 1946 a.m. 5 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 21 1946 to July 6 1946 and that I last saw her alive on July 6 1946

Immediate cause of death

Cardiac failure of the heart
P. Arrows

DURATION

1 mo.

Due to

Due to Diabetes Mellitus

2-3 yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Harold T. Babb M.D. M. D. or other

Address: Port Royal, Md. Date signed: 7/17/46

